This course is primarily a senior seminar capstone for political science majors.

As with any policy area, but seemingly intensified in health care, there are a complex set of considerations influencing policy and what we think policy should be. These considerations borrow from many disciplines including philosophy (moral theory and ethics); economics; management; medical sociology; public health; history; law; and, last but hardly least, political science. There will be some introduction to all of these concerns.

Simply put, the health care problem can essentially be boiled down to three concerns: access to the health care system; the quality of health care; and the costs of health care. Ideally, we would like to maximize access to high quality health care at sustainable levels of cost. Unfortunately, it is not entirely clear that there is an optimization strategy for doing this. Policy analysts call such non-optima problems “wicked problems”. Health care is such a problem. In other words, rationing is inevitable and goes on every day. The principal question is not whether health care is rationed but how it should be. Cost-effectiveness is a pertinent criterion. In the abstract, we usually agree that this is a reasonable criterion but not when it adversely affects our personal interests.

Although all rich countries are experiencing higher health care demand (and costs) as a consequence of their aging demographic profiles and low fertility rates, costs in the U.S. have soared to close to 18% of Gross Domestic Product (GDP) and are expected to rise to at least 20% by the end of this decade. In other words, about 1/5 of the US economy will be devoted to health care. There is a current lull in the rate of cost increase and everyone has a favored and self-interested explanation as to why this is so. However, we really do not yet know why the rate of cost growth has been dampened in the last few years. We do note, however, that temporary declines in the rate of cost growth have been followed by soaring increases. Although costs are increasing in other affluent nations as well, e.g. Canada, Germany, Japan, France and Britain among others, spend far less than does the U.S. as a proportion of their economies. Despite this
greater effort, results in the US tend to be poor. The US health care system spends a great deal more per capita than other rich countries, but the outcomes are no better and, more frequently, a good deal worse. Unraveling why this is so – as well as demonstrating that it is so – is one of the fundamental objectives of the seminar.

In policy analysis, science and facts count for a lot. In politics, ideologies and interests count for a lot. In policy analysis, there are ground rules constraining what one can reasonably infer and what separates fact from fiction. In politics anybody can say anything, no matter its truth value, and have a reasonably good chance of getting away with it. It is fair to say that a great many efforts to reform our health care system have floundered on the rocky shoals of our politics. So, we need to understand the nature of our politics – and why and how it is different from other countries that spend less but achieve more. We also need to understand how our health care system got to be as it has, how major interests – insurance companies, pharmaceutical companies, and health care and hospital systems – have become such powerful players. At the same time, we often engage in wishful thinking that a particular reform or set of reforms will achieve the outcomes we desire without unanticipated negative externalities. We crave certainty but uncertainty clouds policy choice and outcome.

The course also examines prior reforms in health care. The Affordable Care Act (a.k.a. Obamacare or Romneycare) is legislation which affects prior reforms such as Medicaid and Medicare extensively. Those reforms will be examined as will the ACA. The ACA increases access to health care and claims that it will reduce the rise in costs over the course of a decade. That remains to be seen. The ACA is a complex piece of legislation that carries with it numerous regulations, incentives, and emphases on evidence-based medicine. We will examine (at least in bird’s eye view since the bill ran well over 2,000 pages) this legislation, how it came about, and its prospects for widening access, ensuring quality, bending the cost curve, its redistributional effects, and the effects on suppliers of health care.

The gold standard for making wise choices is predicated upon evidence-based practices. However, often the evidence is incomplete or evolving or there are flaws in studies. When do we know enough? We also look at the role that anecdotes play in politicians’ messaging and people’s means of relating to complexity. In this context, we also note the role of interest groups in the health care system and their resistances to evidence that runs counter to their organizational interests.

If you are new to thinking about policy, think in tones of gray rather than black and white. Every good carries a cost. Policy is about tradeoffs although it is often degenerated in political rhetoric to absolutes.

Assignments

There will be two principal assignments for the seminar. The first will be an in-class exam on the Thursday, March 12. It will be closed book and will consist of some multiple choice questions,
some short identifications, and one or two essay questions. You will have the full class session to complete it. Please bring green books, as they are now called, and remember to put your name on the test books. The purpose of this exam is to evaluate your understanding of key concepts, ideas, and data pertaining to health care policy and politics. No computers or digital phones will be allowed to be opened.

The second assignment will involve a group research project that will also demand the ability to argue from different angles or perspectives on a problem. Each group should have at least three members. You will need to work together as a team. Each project will be evaluated as a group effort. However, we will also ask each member of each team to provide me with an assessment of each of their colleagues’ performance in regard to a summary metric and to a discursive assessment of the contributions of each of their peers. This assessment is mandatory. We will provide more detailed instructions as to how to go about this later in the course. Thus, individuals will be graded as well as the project with which they are associated. I will provide a small list of topics and questions and get us down to no more than seven. I will randomly assign the teams so that prior personal friendships or other relationships do not enter into your ability to assess your colleagues’ performance. Most of April will be devoted to preliminary presentations of your findings and assessments and the opportunity to provide feedback for you to work on the final product. You should expect the final product to be in the vicinity of 4,000—5,000 words outside of tables, graphs, diagrams and other data presentations and bibliographic references. Each paper should have a reasonably sized and specified bibliography. Final papers will be due no later than May 4 by 12:00 Noon. During the sessions of April 9, 14, 16, 21 and 23, the teams will present their preliminary findings and have a preliminary discussion paper of a few pages summarizing findings and tentative conclusions. Students not on the presenting team should act as constructive critics of these presentations to assist the presenters in improving the final written product.

In addition, once the seminar really gets rolling, we expect everyone to actively participate and to do so in a way that reflects both being up to date with the readings and clearly focusing on class discussions. This being a seminar, you do not, unlike suspects under U.S. criminal law, have the right to remain silent! If this is going to work as a seminar, you need to be involved, Unexcused absences from class are inexcusable beyond a maximum of three.

**Course Objectives**

There are four principal objectives to the seminar. The first is to enable students to understand the complexity of the health care problem, morally, financially, and politically, and the way it is affected by the characteristics of our social structure and how, in turn, it affects both the welfare of the society and the finances of government, firms, and households. The second is to enable students to compare how the problem of financing health care and insuring citizens (and non-citizens) is met elsewhere. All systems have some problems which they deal with in different ways. The third is to understand the nature of path dependencies built up in any given system over time, how interests are vested, what alternatives become plausible, who has to be paid off, etc. that biases on behalf of the status quo and makes inter-connected change extremely
complicated. Many reforms may be desirable. But few are politically feasible. The fourth is to pay attention to data and hard boiled analysis and tune out the political baloney to find out where the cost drivers in health care are, what the quality of health care is, and who will lose out if the cost curve is significantly bent. To repeat, engagement in the seminar is very important as is preparation in order to engage intelligently.

**Grading Scheme**

The in-class midterm exam will constitute 30% of your grade.

The group research project and your individual contributions to it will constitute 50% of your grade.

Class involvement in regard to both rate and intelligence will constitute 20% of your grade.

**Materials to be Obtained**

There are eight books, all but one in paperback, to be purchased for this course. They are:


The readings for the course will come from these books and some materials to be acquired over the internet, including some other journal articles, working papers, and newspaper articles. There are a few readings that I will scan and attach in an e-mail to you.

In addition, you will be expected to go beyond these readings in your research projects.

**Schedule and Readings:**

**January 13, 15, and 20:**

Intro to Seminar and Overview – Health Care as a Wicked Problem; Pieces of the Elephant – philosophical and moral issues, economic issues, public health and medical issues, the sociology of the medical profession; the business of the medical profession; and the politics of health care; the role of cost shifting in the health care system; access, quality, and costs as values; the relationship of health care to other issues, e.g., budgets, labor markets; path dependencies – interest groups, advocates, practices. How can we know what is true? – measurement, specification, normal science. Analytics versus ideology. Introduction to concepts of adverse selection and moral hazard.

**Reading:**
David M. Craig, *Health Care as a Social Good*, pp. 1-152 (Intro and Chapters 1-4).

Philip M. Rosoff, *Rationing is Not A Four Letter Word*, pp. xi-xiv and pp. 1-34 (Preface and Chapter 1)

**January 22:**

*Professor Bert Chapman, Reference Librarian for Political Science*

Presentation by Professor Albert Chapman, the reference librarian for political science on accessing health care related documents, legislation, and data. You may feel free to continue being in touch with Professor Chapman regarding documents you may need for your projects.

No Reading

**January 27 and 29:**

**Social Insurance and Health – Public Health and Medical Access; the US as Outlier**

**Reading:**


**February 3** – Why is the US an Outlier in Health Care? Dependent Paths, Longevity, and Inequality

Reading:


**February 5 and 10** – Comparative Health Systems – Is the Grass Always Greener?

Reading:


**February 12** – National Parameters, Path Dependencies, and the Fate of Health Care Reform

Reading:

**February 17 and 19** – Cost Drivers and Cost Containment in Health Care

Reading:

Katherine Baicker and Amitabh Chandra, “Defensive Medicine and Disappearing Doctors?” *Regulation* (Fall 2005); 24-31 (via internet).


Rosoff, Rationing is Not a Four Letter Word, pp. 35-60 (Chapter 2).

February 24 and 26 -- The Politics of Health Care: Interests, Fragmentation, Dependent Paths and Entitlement Controversies

Reading:

Brasfield, Health Policy, pp. 165-202.

Jacobs and Skocpol, Health Care Reform and American Politics, expanded edition (whole book)


Miriam J. Laugesen, “Policy Complexity and Professional Capture in Federal Rulemaking” Paper presented at 2013 Annual Meeting of the American Political Science Association, Chicago. (I will provide this paper to you via attachment).

March 3 --The Uninsured, the Underinsured, Moral Hazard, and Uncompensated Care Costs

Reading:

[http://content.healthaffairs.org/content/27/6/w533.full](http://content.healthaffairs.org/content/27/6/w533.full)


**March 5 and 10 – Medicare and Medicaid**

**Reading:**

**A. Medicare**


**B. Medicaid**


Thompson, *Medicaid Politics*.

**March 12**

**MIDTERM EXAM**

**March 17 and 19**

**SPRING BREAK – NO CLASSES**

**March 24 and 26 – The Affordable Care Act (a.k.a. “Obamacare”) – What Will It Do?**

**Reading:**


**March 31 – Evidence Based Health Care**

**Reading:**
Elizabeth Docteur and Robert A. Berenson, “How Will Comparative Effectiveness Research Affect the Quality of Health Care?” The Urban Institute, February 2010: 1-14. 
http://www.urban.org/url.cfm?ID=412040&/renderforprint=1


Rosoff, Rationing is Not a Four Letter Word, pp. 61-220.

April 2 – So Where Are We? Summing Up – What Do We Know and Not Know and What Should We Do?

April 7 – Research Team Presentations: Part 1
April 9 – Research Team Presentations: Part 2
April 14 – Research Team Presentations: Part 3
April 16 – Research Team Presentations: Part 4
April 21 – Research Team Presentations: Part 5

FINAL RESEARCH PAPERS DUE BY MAY 4 at 12:00 Noon.

A Note on Plagiarism

Plagiarism is a form of property theft and intellectual dishonesty. It occurs when you appropriate someone else’s words (or data) without attribution. The consequences of plagiarism are severe. Where I suspect plagiarism has occurred, I will require anyone so suspected to meet with me. Depending upon the nature of the violation, the violator may fail an assignment or the course or be reported for violation of dishonorable conduct. I say this to forewarn you, not to berate you. Please be careful and be specific in citing sources.

Some Possible Research Paper Topics

1. All health care systems engage in rationing of their product. Some systems do it by rationing certain (usually very expensive) procedures; others by limiting access to the health care system itself. Provide both empirical evidence and moral arguments for what works best (or which combination of systems). Remember that any system has to be financially sustainable.
2. One of the fundamental political divides in American health care policy is between social insurance programs and market-based voucher systems. Rep. Paul Ryan (R-Wisconsin), the Republican Vice-Presidential candidate in 2012, former Chair of the House Budget Committee, and current Chair of the House Ways and Means Committee has proposed a voucher plan for future Medicare recipients currently under the age of 55. Each eligible recipient would start off with a minimum $6,000 voucher to purchase health insurance. The amount over time would be adjusted to a revised Cost of Living Index (CLI). Make a case for and against the Ryan plan using data, moral argument, and political assessment. Note how it differs from current Medicare fee for service procedures. Also, examine the current average cost of health care insurance premiums. Is there a risk of adverse selection here? Is there a risk of adverse selection in the current Medicare set-up? On whom, would the costs of adverse selection fall under the Ryan proposal and the status quo Medicare system?

3. The American political system has sometimes been described as where all proposals on health care come to die. Is this so? Explore some of the history of health care reform in the US – including Medicare, Medicaid, S-Chip, the Clinton Health Care Plan, and the Patient Protection and Affordable Care Act (the Obama reform). What factors are involved in success? Which ones are involved in failure? Specify the necessary conditions. Why has health care reform, involving universalized coverage, been so contentious in the United States in contrast to comparable countries?

4. By most “outcomes” data, the US fares relatively poorly when compared to similarly affluent countries. Yet, the US not only spends considerably more of its GDP on health care than its peer countries. It also spends a good bit more per capita than the peer countries. By most standards, this would be described as an inefficient system. What accounts for these inefficiencies, and why do they seem to be so willingly accepted?

5. Assess the fundamental drivers in health care costs. What role seems to be played by politically contentious concerns such as malpractice costs and similar legal liability concerns? What is the evidence of this as a factor? In considering the major drivers, consider also moral issues. For example, 10% of all US health care costs come in a patient’s last year of life as do 25% of all Medicare costs. How should such factors be considered? Note here possible differences in moral theories, especially those emphasizing “categorical imperatives” (“oughts” and “nots”) and those focusing on “consequences” and “outcomes”. What are the costs to society of continued increases in health care as a proportion of GDP?

6. Among efforts to increase transparency and accountability in health care, hospitals and health care providers are now expected to share data on patient readmissions to hospitals as a result of problems arising from the conditions of their hospitalization and to have patients assess their experiences with provider system physicians. Other assessments are
based on peer judgments of hospitals and physicians. Is this likely to add more clarity or more confusion (or perhaps some of both) to assessing the quality of providers? Note the possibilities for gaming such rankings. Note, for example, how universities do the same. Among other things, they often encourage admission applications so they will have a higher rate of selectivity – considered a measure of a university’s quality. Is there any way of appraising health care performance that is not subject to manipulation?

7. T. R. Reid observes four systems of health care – the Bismarckian model of private insurance (but with universal coverage) begun in Germany in the late 19th century; the Beveridge model that inspired the British National Health System (NHS), characterized as a socialized medicine system in which there is a single payer and single provider, namely the government; the National Health Insurance model in which there is a single payer but private providers; and the Out-of-Pocket model of cash for treatment. Discuss the strengths and weaknesses of each of these models. Focus on what we know about how each of these systems perform and ignore the mostly ignorant and demagogic political claims in the US about them. Assuming you had no political or other constraints operating on you, what system would you design? Justify your choice both empirically and normatively assessing the strengths and weaknesses of the alternative systems.

8. The American system of public health insurance is coping with an expected tidal wave of costs as a result of an aging population with its high health care costs and long term care costs. But so are other countries. No health care system is immune from these costs. Please examine any two countries from the following list and assess how they are coping and compare them to the U.S. This exercise will be helpful to understand that all rich countries are in the same demographic boat of aging populations and reduced fertility rates. However, they may differ in other regards including the level of trust toward government, the degree of consensus or conflict in society and the political system, and the nature of governing institutions. Compare any two of the following cases to the US in regard to the nature of the problem and the steps that have been taken and plausible explanations for how the governments have coped: CANADA, UNITED KINGDOM (Britain), FRANCE, GERMANY, the NETHERLANDS, SWITZERLAND, SWEDEN and JAPAN.